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Tips for Supporting a Survivor with Mental Illness/Psychiatric Symptoms

This workshop will explore the impact of sexual violence on people with mental illness or psychiatric disabilities and offer intervention strategies for rape crisis center staff and volunteers. The presentation will discuss diagnoses, stigmatization, risk and the interaction that mental health conditions have with trauma. Participants will gain skills to work more effectively with this population.

- Focus on the survivor as a complete person, not as a diagnosis or label
- Be patient and allow enough time for the survivor to communicate
- If the content of the survivor's speech seems to be delusional, continue to respond without validating the delusions
- Do not laugh at/make fun of the delusional content, appear shocked, or try to dismiss or minimize the experience. Debating the reality of the delusions can increase agitation, defensiveness, and increase symptoms of trauma.
- If the survivor appears to be responding to internal stimuli or hallucinations, do not try to talk them out of it or say, "that is not real". The feelings are very real. You will not be able to talk them out of the delusions or hallucinations. These symptoms may be particularly pronounced after a recent sexual assault, as a new trauma can exacerbate existing mental health symptoms.
- Remember that the fact that some thoughts or experiences may not be based in reality does not mean that an assault did not occur. People with mental illness are targeted by perpetrators because they are often not believed when they disclose the assault.
- Remember that people with mental illness are not "out of reality" most of the time. Having symptoms of mental illness is not the same thing as "making up stories" or "having a wild imagination" the delusions and hallucinations are symptoms of an illness, not "attention seeking". These symptoms do not make people with mental illness more prone to false reporting than the rest of the general population.
- If the survivor has a support person accompanying him/her, resist the temptation to address questions to the support person rather than the survivor, or to speak about the survivor as if he/she is not there.
- Know the difference between a mental illness/psychiatric diagnosis and developmental disability. An adult with a mental illness has the life experience and IQ of any adult. Do not speak to refer to them as "like a child" or speak to them as if they are children. Phrases like "mentally challenged", "slow", or "mentally impaired" do not accurately describe people with mental illness or developmental delays.
- Remember that survivors with mental illness or symptoms of a psychiatric disorder have the right to the same confidentiality and respect as other survivors.

Tips for supporting a survivor with a possible mental illness who is agitated

- Maintain a calm demeanor. If the survivor's affect becomes escalated, become even calmer.
- Take the time to find out why the survivor is reporting, disclosing, or calling your center. What outcome are they expecting or hoping to find?
- If this is during the SART process, find out if the survivor wants to continue to participate in reporting the sexual assault
- Remember that it is common for survivors, especially those with mental illness to use alcohol or drugs to self-medicate or cope with symptoms of trauma and other mental health conditions
- Understand that people with psychiatric disorders face tremendous stigma and are often veterans of many "social service" and "mental health" systems and services. Many have lived on the streets and have been victimized and treated as invisible or less than human. Many have not experienced being treated with respect, being listened to, or validated—make this a different experience.
- Clearly explain your services and any limitations ("It sounds like you are dealing with a terrible situation, I am so sorry -- we do not provide housing, but we do have some referrals I can give you.")
- Specifically address issues such as confidentiality and honestly disclose to the survivor if any information given in the report will be shared and with whom (i.e. if you work in the District Attorney's office for Victim Witness) or could possibly be used against the survivor (this is especially important if the survivor is possibly uncooperative due to being a known sex worker or being under the influence of alcohol or drugs)
- Be clear that being at high risk for sexual assault (being a sex worker, drinking excessively, a teen sneaking out to "date" a much older man, going with a known drug dealer, gang member, or parolee to take drugs, dancing/drinking/passing out at a party or on the streets/in a "drug" house, taking or being sedated by psychiatric medications, etc.) does not cause it. Many survivors are agitated and defensive due to feeling self-blame and are anticipating being blamed by others.
- When at all possible, explain why you need certain information or are asking detailed questions about the survivor's history, behaviors, past mental health services, medications, etc. This will aid in decreasing defensiveness.
- Allow time for the survivor to begin to calm down, asking basic, less challenging questions first
- If the survivor is becoming increasingly agitated, try to discern if this is being caused by a substance, trauma, or other mental health symptoms. If there was recent alcohol or drug use, it is best to see the survivor when sober. Counseling should not occur with an intoxicated person.

The Intersections of Rape Trauma Syndrome and Other Mental Health Diagnoses

| SYMPTOM FROM DSM | SYMPTOM OF RTS |
|---|--|
| Schizophrenia and other Psychotic Disorders | |
| disorganized behavior | difficulty concentrating, reduction in awareness, increase in risky behaviors |
| paranoia | hypervigilance |
| hallucinations | flashbacks/nightmares |
| delusions | cognitive distortions |
| affective flattening | restricted range of affect, numbing of responsiveness |
| lack of goal directed behavior (i.e. organization of meals, self care, etc.) | inability to mobilize assistance/resources clinically significant impairment in social/occupational/academic functioning |
| Mood Disorders | |
| loss of interest | marked decrease of interest/participation in important activities |
| sadness, lethargy/fatigue, emptiness, numbness, anhedonia | sadness, lethargy, unable to feel love, joy |
| feelings of worthlessness and undue guilt | self-blame, worthlessness |
| thoughts of death or suicide | sense of impending doom, suicidal ideations/attempts, sense of a foreshortened future |
| inability to concentrate, indecisiveness, flight of ideas, distractibility | reduction in awareness (being in a daze), difficulty concentrating |
| increased goal directed behavior | perfectionism (efforts to regain control) |
| increased energy | increased arousal (hypervigilance) |
| sleep disturbances | sleep disturbances/nightmares |
| pressure to keep talking | pressure to continually disclose assault |
| excessive involvement in pleasurable activities that have high potential for painful consequences | increased risky behavior |
| Dissociative Disorders | |
| amnesia | inability to recall an important aspect of the trauma |
| unexpected travel or absence from work/school | marked decrease in interest or participation in important activities, clinically significant impairment in social/occupational/academic functioning |
| apparent presence of two distinct identities | description of feeling like one person before the assault and another after, outward adjustment phase (person is perceived as functioning, yet internally is experiencing severe crisis) |
| feeling of detachment from one's body or thoughts | feeling detached or estranged from others, efforts to avoid thoughts, feelings, and activities that remind one of trauma |
| incomplete memories | inability to recall important aspects of the trauma |
| Anxiety Disorders | |
| avoidance behaviors | avoiding reminders of the assault |
| obsessions | intrusive thoughts |
| somatic complaints | body memory during flashback |
| agoraphobia | inability to mobilize assistance/resources, avoiding people, places, activities associated with traumatic event |